WDA Donated Dental Services

WISCONSIN DENTAL ASSOCIATION FOUNDATION

P.O. Box 14173 West Allis, WI 53214-0173 888-338-6852

Donated Dental Services (DDS) Program is a charitable oral care program that works with volunteer Wisconsin dentists to provide comprehensive dental treatment to eligible applicants meeting select criteria. The goal of the DDS Program is to restore an individual's oral health and function to a healthier level they can maintain following the donated care. **As the Program is supported by limited financial grants and donations, implant treatment is typically not supported or provided through this Program.**

ELIGIBILITY: Individuals **may** qualify for dental care through the DDS Program if they have a permanent disability, **OR** are 65 years of age or older, **OR** qualify as medically fragile, **AND** do not have the income to pay for needed care. Applicants **must** demonstrate financial need by providing copies of income statements. Financial limitations are a consideration in the applicant qualification process. **You cannot have access to dental care through Medicaid, Forward Health, Badgercare, Badgercare Plus or Private dental insurance.**

APPLICATION PROCEDURE:

Step One: Please complete the entire application. **Copies of ALL supporting income statements and ALL medical and dental insurance cards (front+back), must be received with the application or it will not be reviewed. Remember to sign and date all consent pages. Submitting an application does not guarantee acceptance into the DDS Program.**

Step Two: When we receive your application, **if** it appears you **may** be eligible, the application is placed into our **wait list** in the order it is received. The wait for application review can be several months to over a year. **Because we are coordinating care with our volunteer dentists and currently approved applicants, we cannot return phone calls with updates on where you are in our wait list.** We appreciate your patience as we are committed to giving each applicant the review and consideration necessary to determine eligibility for the DDS Program.

If you are **NOT** eligible, we will send you a letter of denial and your application with DDS will be closed.

Step Three: When your application moves to the top of the wait list, DDS staff will contact you to gather more information. If it is determined you are eligible, the DDS coordinator will search for a volunteer dentist. If the DDS coordinator successfully locates a volunteer dentist, the DDS coordinator will contact you with the information to schedule an evaluation with the volunteer dentist. **Final acceptance into the Program will be made after the initial evaluation with the volunteer dentist.**

The DDS dentists donate their time and services; they are not paid by us or anyone else. When a DDS dentist decides to treat you, s/he determines the treatment plan. Not all treatment options may be available as donated and may not be appropriate for your individual dental health needs. **When the treatment plan is completed, your treatment with the DDS Program ends. The dentist has no obligation to provide donated care in the future or to maintain you as a patient. It is your responsibility to discuss continuing as a paying patient with the volunteer dentist when your DDS treatment is completed.**

We are sorry you are experiencing a dental problem and we hope the Donated Dental Services Program may be a source of help. If you require immediate or emergency care, please see the low cost clinic resource list at www.wda.org/for-the-public/low-cost-dental-clinics

PLEASE KEEP THIS PAGE FOR YOUR RECORDS

APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM

Mail application to:

Wisconsin Donated Dental Services
P.O. Box 14173
West Allis, WI 53214-0173
(888) 338-6852

Today's Date: _____

APPLICANT INFORMATION (Please circle or mark X in appropriate areas)

Name:_____**Phone**: (_____)_____(**home**)

Address:_____**Phone**: (_____)_____(**cell**)

City:_____**State**:_____Zip Code:_____County:_____

Own ☐ **Rent** ☐

Email Address: _____**Date of birth**: _____**Age**: _____

Military Veteran: **Y/N Branch served**: _____

Marital status: **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated** ☐

Emergency Contact Person Name (***relative, friend, etc***.)_____

Phone: (_____) _____Relationship to you:_____

Have you received services through the DDS program before? **Yes** ☐ **No** ☐ **If yes, in which state**? _____

*__How did you hear about the DDS program__? _____

Medical/Health Information

Primary Physician's name: _____

Phone: (_____)_____**Date of Last Visit**: _____

Do you use a: Wheelchair ☐ **Cane** ☐ **Walker** ☐ **Scooter** ☐ **Hearing Aid** ☐

Do you require wheelchair access? Yes ☐ **No** ☐

Please circle all that apply

Artificial heart valve/stent	**Diabetes**	**Heart Problems**	**Osteoporosis**
Organ Transplant	**Cancer**	**Multiple Sclerosis**	**Dialysis**
Rheumatoid	**Autoimmune disease**	**Organ Transplant**	**Anxiety**
Mental Health Diagnosis	**Bi-Polar**	**Depression**	**Pacemaker**
Artificial Joint/other orthopedic	**Traumatic Brain Injury**	**Fibromyalgia**	**Schizophrenia**

Please explain in more detail if you circled any of the above or list Other

_____

_____

_____

_____

_____

_____

HOUSEHOLD and FINANCIAL INFORMATION:

Number of people in your household: ____

Name of each person in the household:	**Age**:	**Relationship to you:**	**Monthly Income**
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

***If you are NOT receiving disability, have you ever applied? Yes: ☐ No: ☐

Employment information:

Are you able to work? Yes: ☐ No: ☐

If **NO** explain **why**: _____

Your place of employment: _____

Your monthly employment income: $_____

Is your spouse/significant other employed? Yes: ☐ No: ☐

If **NO**, explain **why**: _____

Spouse/Significant other place of employment: _____

Spouse/Significant other's monthly employment income: $ _____

INCOME SOURCES:

CIRCLE ALL THAT APPLY	**MONTHLY AMOUNT:**	**YR BENEFIT BEGAN.**
SSI OR **SSDI**	$ _____	_____
Social Security Retirement	$ _____	_____
Pension	$ _____	_____
Unemployment/Worker's Compensation	$ _____	_____
Other (explain)_____	$ _____	$ _____
TOTAL MONTHLY HOUSEHOLD INCOME	**$ _____**	
Total Value of Savings/Checking	$ _____	
Total Value of Investments	$ _____	

Please list Investment type: _____

	Monthly Payments		**Monthly Payments**
Mortgage/Rent	**$_____**	**Utilities/Gas/Electric**	**$_____**
Home/Rent Insur.	**$_____**	**Heat included-circle one:**	**Y/N**
Water/Sewer	**$_____**	**Phone**	**$_____**
TV/Internet	**$_____**	**Car Payment/Lease**	**$_____**
Car Insurance	**$_____**	**Gas/Car Expenses**	**$_____**
Health Insurance	**$_____**	**Life Insurance**	**$_____**
Medications/RX	**$_____**	**Other Medical**	**$_____**
Food stamps: Y/N		**Food (not including food stamps)**	**$_____**
Other expenses not listed	**$_____**	**Smoker: Y/N if yes->**	**$_____**

Medical + Dental Insurance Information

Do you receive **Medicaid, Forward Health, Badgercare, Badgercare Plus** benefits? (*circle one+check box below*)

Yes: ☐ No: ☐ **Medicaid Member ID# (**10 digit number) _____

Do you receive **Medicare** benefits? Yes: ☐ No: ☐

Do you have a **Medicare Supplement** Yes: ☐ No: ☐ Plan: _____

Do you have **Private Dental Insurance**? Yes: ☐ No: ☐ Plan: _____

Items required when submitting an application to the Donated Dental Services Program are listed below. An application cannot be reviewed or considered without this information and will be automatically denied. DO NOT SEND ORIGINIALS, ONLY COPIES.

- A copy (front + back) of **ALL Medicare**, **Medicaid** and **Private Dental Insurance cards** with your application.
- A copy of your **Social Security Income (SSI) statement**
- A copy of your **Social Security Disability Income (SSDI) statement** (State of WI or Federal Government)

If you have someone helping you fill out your application, please list their name and phone number:
Name_____ **Phone #** _____

Are there any other sources of income to contribute to your dental care? (family member, church, service organizations, etc.) Please list below.
Name_____ **Phone #** _____ **Relationship** _____

Transportation

Is there a car(s) in the household? Yes: ☐ No: ☐ **Multiple vehicles**? Y/N

Make:_____ Model: _____ Year of car: _____

If **NO**, how would you get to your dental appointments? _____

REFERRING AGENCY or AGENCY THROUGH WHICH YOU RECEIVE SERVICES (VA, ADRC):

Agency name: _____

Name of caseworker:_____Phone: (_____)_____

Address_____Fax: (_____)_____

City:_____ State:_____ Zip: _____

ADDITIONAL INFORMATION:

Use this space to elaborate on any information not sufficiently explained in other areas:

_____

_____

_____

_____

DENTAL INFORMATION

Briefly describe your dental problems:

Please count your existing natural teeth then list # of Upper Teeth: _____ # of Lower Teeth: _____

Name of last dentist:_____Phone: (___) _____

Approximate date of last dental visit:_____Services Performed _____

Do you have? (Check all that apply):

Denture ☐ Partial ☐ Bridge ☐ Crowns ☐

I have had a denture, partial, or bridge in the past but **NOT** anymore: Y: ☐ N: ☐

How will you get to dental appointments? _____

How far you are willing to travel in order to get dental treatment (list cities or miles) _____

Do you have anxiety when thinking about or going to a dentist? Y ☐ N ☐ mild/moderate/severe (circle)

What other barriers do you face when trying to obtain dental care? Please describe.

✪ STOP ✪

Please review all the information you have entered on the application and make sure it is accurate and complete. Next, make sure the Consent and Release Forms are both signed and dated. If they are not signed and dated we will not be able process your application. Lastly, remember to include copies of all required documents for application review.

OPTIONAL PHOTO AND INFORMATION CONSENT FORM:

I give permission to the WDA Foundation-DDS Program to use my name, information, statements, or photograph for public relations purposes, and to attribute my statements to me as an expression of my personal experience. I understand that this information may be used in dental journals, website, media articles, advertisements or other marketing materials that promote the WDA Foundation-DDS Program and encourage involvement from dental professionals and funders. I also agree that no material needs to be submitted to me for any further approval, and I give the WDA Foundation-DDS Program the right to copyright such material if necessary. I understand that if I do not grant permission for the DDS Program to use my name, information, statements or photograph, it will *not* affect my eligibility for receiving services through the DDS Program.

Client's Signature (Required):_____Date: _____

Signature of Client's Guardian (if applicable):_____Date: _____

Signature of Referring Person (if applicable):_____Date: _____

Donated Dental Services Primary CONSENT Form

Please read this CONSENT form carefully. If you understand and agree to each of the conditions below, please sign and date the form where indicated to confirm your CONSENT to apply for the Donated Dental Services program ("DDS Program"), which is coordinated by the Wisconsin Dental Association Foundation (WDA Foundation). If you do not understand or agree with each of the specific conditions below, you should NOT sign this form or apply to participate in the DDS Program. Participation in the DDS Program is conditioned upon written CONSENT to the conditions below.

CONSENT TO USE MY PERSONAL INFORMATION- I understand that I will need to provide personal information that includes but is not limited to medical, dental, and information about my financial condition. Further, I give my consent for the referral coordinator to obtain my personal information from my physician, dentist, individuals who know me, and/or government or private agencies that will be used to determine whether I may be eligible for the DDS Program. I also give my consent for the referral coordinator to share my personal information with one or more volunteer dentists in the DDS Program. If I have any disease or disability (including AIDS or HIV related issues), I give my consent to the WDA Foundation to release information about my medical condition and agree to hold the WDA Foundation harmless for doing so.

TREATMENT IS NOT GUARANTEED– I understand that my application to the DDS Program **does not guarantee** that I will receive treatment, be referred for an examination, or that I will be accepted as a patient following an examination, should an examination be completed. I understand and agree that the decision of the DDS Program is final and I agree to accept and be bound by that decision.

LIMITED SCOPE OF TREATMENT BY A VOLUNTEER DENTIST - I understand that the WDA Foundation, which coordinates the DDS Program, will determine whether I am eligible for the DDS Program and, if so, will seek to refer me to a participating volunteer dentist. I further understand that the volunteer dentist, not the WDA Foundation, is solely responsible for the diagnosis and dental treatment that I might receive.

I understand that the volunteer dentist has agreed to treat my existing dental condition **only** and is **NOT** obligated to provide donated dental care in the future or to keep me as a patient. Further, I understand that a volunteer dentist in the DDS Program may discontinue providing services to me at any time after providing notice to me. I understand that, after receiving such notice, if I wish to continue receiving dental treatment, it will be my obligation to obtain services elsewhere. I understand that the WDA Foundation– DDS Program has no responsibility to assist me in obtaining other dental services.

I understand that if I need immediate or emergency dental care, I should and will seek such treatment outside of the DDS Program.

I understand the importance of keeping all scheduled appointments, and that failure to do so, without at least 24 hour notice to the volunteer dentist, will disqualify me from obtaining further treatment through the DDS Program.

To the best of my knowledge, the information provided on this form is a full and accurate disclosure of my current physical, mental and financial status.

Client's Signature (Required):_____ Date: _____

Signature of Client's Guardian (if applicable):_____ Date: _____

Signature of Referring Person (if applicable):_____ Date: _____

Donated Dental Services Primary RELEASE Form

Please read this RELEASE form carefully. If you understand and agree to each of the statements below, please sign and date the form where indicated to confirm your agreement to RELEASE the Wisconsin Dental Association Foundation (WDA Foundation),which coordinates the Donated Dental Services program (DDS Program). If you do not understand or agree with each of the statements below, you should NOT sign this RELEASE form or apply to participate in the DDS Program. Participation in the DDS Program is conditioned upon your written RELEASE of the WDA Foundation.

RELEASE OF THE WDA FOUNDATION FOR USE OF MY PERSONAL INFORMATION- I understand that I will need to provide personal information including but not limited to medical, dental, and financial information as a condition of applying to and participating in the DDS Program. I have consented to the use of my personal information in order to apply for and/or participate in the DDS Program. I hereby expressly RELEASE the WDA Foundation from any direct or indirect claim, demand or cause of action relating to/or arising from the use of my personal information for application to, or participation in, the DDS Program.

RELEASE OF THE WDA FOUNDATION FOR TREATMENT- I understand that the WDA Foundation, which coordinates the DDS Program, will determine whether I am eligible for the Program and, if so, will seek to refer me to a participating volunteer dentist. I further understand that the volunteer dentist, not the WDA Foundation, is solely responsible for the diagnosis and dental treatment that I might receive. I hereby expressly RELEASE and HOLD HARMLESS the WDA Foundation from any claim, demand or cause of action relating to, or arising out of the dental treatment I receive through participation in the DDS Program, including but not limited to any injury or damage resulting directly or indirectly related to treatment or failure to treat.

I acknowledge and agree that this RELEASE is freely given in exchange for the opportunity to apply to participate in the DDS Program.

To the best of my knowledge, the information provided to the DDS Program is a full and accurate disclosure of my current physical, mental and financial status.

Client's Signature (Required):_____ Date: _____

Signature of Client's Guardian (if applicable):_____ Date: _____

Signature of Referring Person (if applicable):_____ Date: _____